MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Surgical and Diagnostic Center, LP 729 Bedford Euless Road West, Suite 100 Hurst, Texas 76053	MDR Tracking No.: M4-03-7462-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Company Rep. Box 19	Date of Injury: Employer's Name: Lear Corporation Insurance Carrier's No.: YBUC 27889

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/29/02	05/29/02	29826 – Arthroscopy, shoulder	$5246.97 (Carrier paid $1118)	-0-
05/29/02	05/29/02	85025 - CBC	$37.00	-0-
05/29/02	05/29/02	86311 - HIV	$50.00	-0-
05/29/02	05/29/02	80005 – Electro Panel II	$44.00	-0-
01/17/03	01/17/03	29826 – Arthroscopy, shoulder	$3745.90 (Carrier paid $1118)	-0-
01/17/03	01/17/03	80004 – Electro Panel	$44.00	-0-
01/17/03	01/17/03	86311 - HIV	$50.00	-0-
01/17/03	01/17/03	93005 - EKG	$35.00	-0-
01/17/03	01/17/03	93010 – EKG Interp.	$15.00	-0-
			Total Amount Due:	-0-

PART III: REQUESTOR'S POSITION SUMMARY

Our charges are fair and reasonable based on other insurance companies determination of fair and reasonable payments of 85-100% of our billed charges. Workers' Compensation Carriers are subject to a duty of good faith and fair dealing in the process of workers' compensation claims.

PART IV: RESPONDENT'S POSITION SUMMARY

No fee or MAR. Carrier paid fair and reasonable.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these

types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 173.9% - 256.3% of Medicare for 2002-2003). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, the original reimbursement on these services is within the low end of the Ingenix range. All the CPT Codes other than 29826 are included in the facility fees and are, therefore, not payable. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Finding and Decision by:

		07/28/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____